

COORDINATING AND INTEGRATING CARE FOR SAFETY NET PATIENTS: LESSONS FROM SIX COMMUNITIES

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Case Study: St. Louis, Missouri

Background

St. Louis is the second largest city in Missouri, with an estimated population of about 355,000 residents in 2009.³¹ Nearly one-quarter (24.4 percent) of the city's residents are poor; median family income, at \$41,349, is approximately one-third below the national average.³² Half (49.5 percent) of the city's residents are Black or African American,³³ 2.9 percent are Hispanic or Latino and 2.4 percent are Asian.

The St. Louis health care safety net consists of many different organizations that provide primary, specialty, inpatient, dental and mental health services to uninsured and underserved populations in both St. Louis City and St. Louis County.³⁴ About one-quarter of the city/county's 1.3 million residents are estimated to be uninsured or covered by Medicaid, thereby comprising the population that is likely to seek care from these safety net providers.

In 2009, more than 630,000 primary care encounters took place at 33 separate sites of care.³⁵ Four Federally Qualified Health Centers (each operating at multiple sites) provide the lion's share of primary care for uninsured and Medicaid-covered patients; these are Grace Hill, the Betty Jean Kerr People's Health Center, Myrtle Hilliard Davis, and Family Care. Additional urgent care services are delivered by St. Louis ConnectCare, an organization formed following the closure of Regional Medical Center, using Regional's facilities and operating on the same site where people had come for years to receive safety net services. St. Louis County health centers also provide significant primary care services for safety net patients. More limited services are available for safety net patients through hospital based primary care clinics, free-standing clinics and community primary care physicians.

ConnectCare also provides specialty care for uninsured patients in the St. Louis area. Uninsured patients are referred by primary care providers to ConnectCare, which provides specialty care on site and through vouchers for specialist or diagnostic/therapeutic services at hospitals or other community providers. In 2009, ConnectCare provided uninsured patients approximately 13,000 encounters with specialists. Washington University's adult medicine clinics provide a similar number of specialist services to uninsured patients; more limited numbers of specialty visits are offered by local hospitals including St. Louis University (SLU)

³¹ US Census Bureau, 2005-2009 American Community Survey. St. Louis, Missouri. Available at: http://factfinder.census.gov/home/saff/main.html?_lang=en.

³² The US median family income in 2009 inflation-adjusted dollars is \$62,363. See #1 citation.

³³ Refers to individuals who report race alone or in combination with one or more other races.

³⁴ St. Louis became an independent city in 1876 and is not part of any separate county structure. In terms of governance, St. Louis operates as a city and a county. St. Louis County is a separate governmental entity surrounding St. Louis City.

³⁵ St. Louis Regional Health Commission. *Progress toward Building a Healthier St. Louis: 2010 Access to Care Report*. Available at: <http://www.stlrhc.org/LinkClick.aspx?fileticket=Qi1NUJukLp8%3d&tabid=38>

Care, St. John's and BJC Hospitals.³⁶ In 2009, Medicaid and uninsured patients had more than 200,000 specialty visits across these providers.

A Troubled Past

The health care safety net in St. Louis has a precarious history.³⁷ St. Louis was once home to two public hospitals: Homer G. Phillips Hospital, which trained African American physicians and nurses and provided health services primarily to the city's African American patient populations; and St. Louis City Hospital, a site of care for many low-income white patients. This delicate equilibrium of "separate but equal"³⁸ health care began to collapse in the late 1970s, first with the closure of Homer G. Phillips Hospital in 1979 and then with St. Louis City Hospital shutting its doors in 1985. The response to the health care crisis created by these closures, by this time affecting both black and white residents, was the creation of St. Louis Regional Medical Center, a not-for-profit hospital with an explicit safety net mission. Despite some restructuring and a 10-year contract from the city and county health departments, Regional did not present a viable financial model for delivering care to uninsured and underinsured residents. In 1997, Regional closed its operations as well.

Remarkably, despite Regional's closure, some components of the St. Louis health care safety net have flourished over the past decade. In large measure, this is due to a set of strategic alliances that operate with a commitment to move the safety net beyond a contentious, fragmented history toward a more coordinated, higher-quality, better resourced future.

Current Initiatives

Repairing a Fragmented Safety Net

The closure of Regional Medical Center appears to have served as the catalyst for a spirit of collaboration and coordination in the St. Louis health care market. In 2001, the St. Louis Regional Health Commission was formed to ensure the financial stability of the safety net, develop an integrated health system for uninsured and vulnerable patients in the community, and implement a business plan to restructure the St. Louis safety net.³⁹ Working under the direction of a charismatic CEO, the Regional Health Commission (RHC) managed to engage the participation of key stakeholders across the safety net and the broader health care market.

³⁶ BJC Healthcare is a large health system that includes 13 hospitals in and around the St. Louis area. It includes teaching hospitals (Barnes Jewish and St. Louis Children's Hospital) as well as community hospitals and other delivery sites.

³⁷ Jordan, S. "RHC addresses diverse healthcare needs of St. Louis area". St. Louis American. July 22-28, 2010. Available at: http://www.zwire.com/site/dav.cfm?brd=3157&dept_id=694223&pag=1027&ssid=18561&vw=article.

³⁸ Personal communications with interview subjects, March 2011.

³⁹ St. Louis Regional Health Commission. *Building a Healthier St. Louis: 2003 Access to Care Report*. Available at: <http://www.stlrhc.org/InitialReport.aspx>

A 2002 amendment to Missouri's Medicaid 1115 waiver created a mechanism for the RHC to hold onto about \$25 million a year in much needed funding that had previously flowed to St. Louis Regional Medical Center.⁴⁰ The money is distributed to safety net providers, including FQHCs and ConnectCare, an outgrowth of Regional Medical Center that provides urgent care and specialty services to underinsured and underserved residents of the community. Other sources (including St. Louis City and direct service payments) provide additional safety net support. The RHC issues regular reports on trends in use and availability of safety net services and support efforts to expand access, streamline Medicaid enrollment, and create uniform policies and processes related to out-of-pocket payments at local FQHCs. The RHC reports a steady rise in the number of primary care and specialty visits provided over the past decade, while reducing wait times for specialty visits for the uninsured by 85 percent.⁴¹

In its October 2003 report, *Recommendations for Improving the Delivery of Safety Net Primary and Specialty Care Services*, the RHC recommended that current safety net providers form a permanent regional network to coordinate and integrate care to the medically underserved. This was followed by a federal grant from the Health Resources and Services Administration (HRSA) supporting the creation of such a network. In 2003, administrators from the area's largest outpatient safety net providers formed the St. Louis Integrated Health Network (IHN). The IHN serves as a trusted broker for safety net ambulatory care providers, organizing its work around projects aimed at improved care coordination and service integration and sharing of clinical best practices across the community.⁴² Much of the work around care coordination is planned and implemented through the IHN's Primary Care Home Initiative, which seeks to link Medicaid and uninsured patients with a primary care home, reduce non-emergent ED use, and enhance coordination, quality and efficiency of care through the secure electronic exchange of patient health information. Two such programs, funded through a combination of CMS waiver dollars, a targeted CMS grant and in-kind safety net provider support, are especially noteworthy.

The Community Referral Coordinator Program (CRC) is a joint undertaking between community health centers and hospitals, with the IHN serving as the "boots on the ground" to facilitate linkages between emergency department patients and primary care homes. IHN hired, trained and placed Community Referral Coordinators in hospital emergency departments to 1) flag patients without a usual source of care; 2) talk with patients at the bedside in the ED to determine whether the patient has an interest in a follow up appointment at a conveniently located community health center and schedule an appointment for the patient. The CRC provides brochure materials and information about the importance of effective primary care to patients who demonstrate any interest in the service. If patients have prior relationships with community health centers that they wish to continue, the CRC will follow up with the specific site. If the patient is in need of establishing a primary care home, the CRC will work with the patient to select one and schedule an appointment. The CRC follows up with the patient to explain the importance of the appointment, provides the physician's name and location of the health center

⁴⁰ Safety net hospitals in the community agreed to forgo claim to these dollars, which come from the Medicaid Disproportionate Share Hospital Payment program to support hospital-based care for Medicaid and low-income patients.

⁴¹ Saint Louis Regional Health Commission. *Progress toward a Healthier St. Louis*. Report to the Community 2002-2007. Page 3.

⁴² Saint Louis Regional Health Commission. *Progress toward a Healthier St. Louis*. Report to the Community 2002-2007. Page 10.

(plus directions if requested), and answers any other questions the patient may have. The CRC also sends an appointment reminder postcard or provides a reminder phone call 24 to 48 hours prior to the appointment. The IHN follows up with community health centers to collect data including show rates and reports out to the community and additional stakeholders for feedback.

The program works best when the hospital ED has an electronic medical record that provides real-time information about potential CRC patients. The EMR in the ED at Barnes Jewish Hospital, for example, includes an icon next to the patient's name indicating that the patient does not have a primary care home. Referral coordinators can view current patients at terminals in the ED and check to see which patients to offer primary care follow up. If a patient is interested in a primary care appointment, the referral coordinator immediately calls the community health center to schedule an appointment. Community Health Centers have made special arrangements, including a direct scheduling line, to support easy and quick access to scheduling requests coming from CRCs. This allows the patient to walk out of the emergency room with an appointment in hand which facilitates a greater likelihood of connection with the primary care home.

The CRC program has seen some immediate successes. Since June 2007, over 40,000 patient encounters have taken place as part of the CRC program.⁴³ Initially about one-quarter of these encounters resulted in a scheduled appointment; however, currently 56 percent of encounters result in a scheduled appointment. Patient "show" rates at follow-up primary care appointments have increased after implementation of the program, with some community health centers seeing more than 50 percent of patients referred from the ED keeping their appointments. This compares favorably to anecdotal reports of rates in the 20 percent range prior to the CRC program. The program has also enhanced communication across hospitals and community health centers, allowing for greater collaboration in future activities. CRCs are currently stationed in seven hospitals. There are also plans to integrate the CRC model with inpatient care in an effort to reduce low acuity readmission rates. One local hospital has begun funding a CRC for inpatient care coordination.

A major planned initiative of the St. Louis Integrated Health Network (IHN) has been the *Network Master Patient Index (NMPI)*, a health information exchange for major safety net providers in the St. Louis area. The NMPI includes patient information from five FQHC and seven hospital emergency departments, as well as ConnectCare and the St. Louis County Department of Health's health centers. Use of the NMPI is designed to reduce non-emergent ED use, cut waste (for example, redundant lab tests), enhance real-time communication across providers, and most importantly improve care for patients. The health information exchange is specifically for care coordination of all patients including the uninsured and Medicaid populations. Plans for the NMPI have been placed on hold, given new activities related to the development of a state health information exchange, spurred by the federal American Recovery and Reinvestment Act efforts to spur health information technology, to see how such efforts can be integrated with broader plans in the state.

⁴³ St. Louis Integrated Health Network. Community Referral Coordinator Program Update, October 1st – December 31st 2010.

The first generation of NMPI data will include ED summaries and patient demographics; over time, information on allergies, medications, laboratory values and other diagnostic and treatment information will be added to the patient record. Participating providers will be able to see information exclusively about their own patients. Information will be placed in separate “vaults,” with patient information made available at the provider level by a patient matching function to assemble all relevant patient information. When a patient presents for care at one of the FQHCs, for example, the health professional caring for that patient will be able to pull up the patient record and see where the patient has received treatment prior to the encounter. Notes on ED visits, inpatient stays, or care from other clinics within the safety net would be available for review. NMPI also includes a secure messaging function for physicians and other health professionals, signaling that laboratory results are ready, or that the patient has had an ED visit.

The strength of the IHN is in its ability to foster collaborative problem solving through a system of cross organizational work groups that provide oversight to and recommendations for improvement at both an organizational and systemic level. The IHN has a Reform Ready Steering Committee that consists of all health center Chief Operating Officers that is focusing on developing uniform best practices across health centers and sharing resources to best prepare for the implementation of healthcare reform in 2014. The NMPI is overseen by a steering committee and multiple smaller planning groups to ensure that implementation meet all legal, ethical, and patient concerns and comply with local, state, and federal guidelines. The Community Referral Coordination Task Force consists of both health center and hospital leadership to provide oversight to the CRC program and implement recommendations to streamline access to primary care and improve the transition of care from hospitals to health centers.

Integration of Behavioral Health and Primary Care

The St. Louis Regional Health Commission is also working to address the severe fragmentation of behavioral health services in the area. Over the past several years, a series of working groups and task forces have identified a vision and set of recommendations to create a more responsive, coordinated and accessible adult behavioral health care system in the St. Louis region.⁴⁴ The success of the safety net work and the Integrated Health Network served as a model to focus attention on issues related to behavioral health. As part of its response, the Regional Health Commission created the Behavioral Health Network as a separate entity to elevate the issue of mental health and substance abuse, encourage “ownership” of the process on the part of behavioral health providers, and allow the complex issues associated with mental health and substance abuse treatment to percolate and develop with the behavioral health community.

In a step toward integration, in 2007, the Crider Health Center – a community mental health center – received FQHC status and transformed itself from a community mental health provider to a full-service community health center, offering a comprehensive set of primary,

⁴⁴ St. Louis Regional Health Commission. *Pathways to Progress: Transforming the Behavioral Health System: 2006-2010.*

dental, mental health and other services to residents in the western part of St. Louis. The success of the Crider integration of mental health and primary care services spurred a similar merger in the eastern region of the St. Louis area. In 2010, the Betty Jean Kerr People's Health Center merged with a Hopewell Center, a major mental health safety net provider in the community. Since these mergers, other community health centers have pursued efforts to co-locate primary care and mental health services and facilitate ease of access to a full range of behavioral and physical health care.

Future Challenges

In its first decade, the St. Louis Regional Health Commission has preserved more than \$200 million in safety net funding through extensions of the Medicaid 1115 waiver. However, extending the waiver for an additional time period seemed uncertain as the latest waiver period was nearing an end without a clear strategy toward a sustainable financial model moving forward.

In July 2010, the St. Louis Regional Health Commission received an extension of the waiver, called the Gateway to Better Health Demonstration Project. The Gateway project requires that the Regional Health Commission transition from a direct payment model to a coverage model. Plans for movement toward a coverage model were due to CMS in July 2011 with implementation scheduled for one year later. These steps are meant to create a bridge to maintain the capacity and quality of the health care safety net until a sustainable financial model becomes feasible with the full implementation of health reform. While specifics about the interim coverage model are yet to be decided, the Regional Health Commission will retain approximately \$25 million annually through 2013.